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# **AN APPLICATION OF ACCEPTANCE AND COMMITMENT THERAPY AS IT RELATES TO CHILDREN**

by

Laura Anne Wright

Thesis submitted in partial fulfillment  
of the requirements for the degree

of

DEPARTMENTAL HONORS

in

Human Movement Science, Exercise Science Emphasis  
in the Department of Health, Physical Education and Recreation

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Spring 2013



Acceptance and Commitment Therapy in the Treatment of Obsessive-Compulsive Disorder

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**Abstract**

This paper expounds upon a modern therapy which has emerged as an effective, albeit less conventional, mode for the treatment of people with Obsessive-compulsive Disorder (OCD). Acceptance and Commitment Therapy, or ACT, is a therapy based on the premise that an effective way of coping with unwanted cognitions, such as those present in OCD, is for one to focus on life ideals and values. This approach contrasts with the conventional method of remedying the symptoms of a mental disorder such as OCD before pursuing life goals. Acceptance and Commitment Therapy has several dimensions which will be discussed.

OCD is an anxiety disorder in which a person experiences undesired and disturbing cognitions which prompts them to respond in some way. Usually the person feels this response is the only adequate solution to the unwanted cognition. These symptoms must create problems in the person's life to in order to be diagnosed with OCD.

A review of the criteria for OCD follows:

- Obsessions: recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate, and cause marked anxiety or distress; are more than just excessive worries about real life problems; the person attempts to ignore or suppress or neutralize them; the person recognizes that the thoughts, impulses, or images are a product of her or his own mind.
- Compulsions: repetitive behaviors (e.g., frequent hand washing or checking) or mental acts (e.g., praying, counting) that person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
- Recognition that the obsessions or compulsions are obsessive and unreasonable.
- The thoughts, impulses, or behaviors cause marked distress, consume more than an hour each day, or significantly interfere with a person's normal functioning or relationships" (American Psychiatric Association, 2000).

OCD is a debilitating anxiety disorder. Other psychological disorders, such as generalized anxiety disorder, major depression, panic attacks, and avoidance commonly accompany OCD. Having such a cluster of symptoms with at least two disorder diagnoses is known as co-morbidity. Thus, OCD has a high rate of co-morbidity. With OCD, it is difficult to feel as though one can safely engage in the daily activities of living. A person with OCD may

feel such minute control over life events that she or he establishes rituals or patterns to help create a sense of security or predictability. As written by Durand and Barlow (2003), “A client referred for psychosurgery because every psychological and pharmacological treatment has failed and the suffering is unbearable probably has OCD” (p.151).

In most anxiety disorders, the feared object or stimulus commonly stems from the external environment. However, in OCD the feared stimulus often does not come from the external environment; rather, the disturbing stimulus is a thought, impulse or image that comes from within. Because the source of the feared stimulus in OCD is internal, the client has difficulty evading it. A person with OCD may attempt to suppress or avoid these internal stimuli with as much vehemence as a person with arachnophobia avoids spiders. In a study by Ólafsson Emmelkamp, Gunnarsdóttir, Snæbjörnsson, Ólason, & Kristjánsson (2013), it was shown that thought suppression may not be an effective long-term means of coping with obsessions. Durand and Barlow (2003) provided a helpful analogy: “Has anyone ever told you not to think of pink elephants? If you really concentrate on not thinking of pink elephants, using every mental means possible, you will realize how difficult it is to suppress a suggested thought or image. Individuals with OCD fight this battle all day, every day, sometimes for most of their lives, and they usually fail miserably. Anxiety disorder involving unwanted, persistent, intrusive thoughts and impulses as well as repetitive actions intended to suppress them” (150).

Obsessions can be defined as strange or frightening thoughts but the overlying theme of an obsession is that they are internal cognitions which are distressing to the person experiencing them. The person tends to think these unsettling thought patterns over and over. Compulsions are the behaviors implemented by the person who is experiencing obsessions in order to better deal or cope with the obsession. Oftentimes the compulsion is simply created in the mind of the

individual experiencing obsessions. The compulsion may or may not directly relate to the subject matter of the obsession. Compulsions do not have to make sense to the outside world. They are simply behaviors that have a consequence of relieving or seeming to relieve the negative emotions incited by the obsession. A person is diagnosed with OCD when they experience both obsessions and compulsions which take a negative toll on the functionality of their lives (Twohig, Plumb, Mukherjee, & Hayes, 2009).

OCD is a fairly commonly diagnosed psychological disorder. It is estimated that about 1% of the population in the United States has OCD (Kessler, Chiu, Demler, & Walter, 2005). For most people, the onset of the disorder occurs around ages 13-19, with onset in females being earlier. The pediatric clinical cases of OCD show a 3:2 male to female ratio (Hanna, 1995). In later life, however, there are a higher percentage of females diagnosed with OCD as compared to males (Twohig, et al., 2009).

It is interesting to note that individuals with an OCD diagnosis have a high rate of comorbidity, meaning they often have another type of disorder along with the OCD. It is estimated that approximately 50-75% of people with OCD have some other type of psychological disorder (Anthony, Downie, & Swinson, 1998). The individual may have another type of anxiety disorder or another classification of disorder such as mood or a substance related disorder. Specific disorders that frequently co-occur with OCD include body dysmorphic disorder, substance dependence, Tourette's disorder, and eating disorders such as Anorexia Nervosa (Anthony, et al., 1998).

There are different sub-types of OCD. OCD can be categorized according to the type of compulsion the person has chosen to implement. Although compulsions are individually chosen

and unique, many follow similar patterns and processes of thought construction. Some of these categories of compulsions include: obsessional slowness, primary obsessions, checking, symmetry, and hoarding. Most people with OCD have more than one obsession and compulsion. These obsessions and compulsions have differing dominance and intensity but there is typically a primary obsession with its reactive compulsion (Taylor, McKay, & Abramowitz, 2008).

Generally, when a person comes into a clinic to be treated for a psychological disorder, they expect their treatments to result in an increase in the quality of life. Many people would think that the first step a psychologist would take in creating a better quality of life would be to attend to their symptoms. With OCD the patient is often expecting initial treatment of their obsessions and compulsions. In this regard, ACT might appear unconventional because it is not so based around the symptoms (such as obsessions and compulsions) as it is on quality of life. This focus on quality of life is also typically consistent with the patient's ultimate goals (Twohig, et al., 2009).

ACT is largely founded upon a philosophy called functional contextualism. Functional contextualism does not have to with how things work as much as assuring that they do indeed work. A goal of ACT is to "help the client function in a way more consistent with their values rather than symptom reduction" (Twohig, et al., 2009; p. 259). The techniques do not necessarily need to model reality and alleviate all negative symptoms that come with OCD. Functional contextualism as applied in ACT is not just interested in reducing symptoms and distress in a clinical setting but allowing the patient to find ways to apply and accomplish goals in life. More important than creating a uniform "reality" and reducing negative symptoms is increasing the quality of the person's life (Twohig, et al., 2009).



According to Twohig, et al. (2009), ACT “has less of a focus on symptom reduction and a greater focus on increasing quality of life” (p.258). Quality of life takes precedence over symptoms, which may come in the form of heightened fear, anger, or distress. It is interesting to note is that according to the diagnosis for OCD as found in the *Diagnostic and Statistical Manual of Mental Disorders*, in order to have a clinical diagnosis of OCD the patient must experience impaired functioning and heightened distress. This focus on quality of life makes sense because it is the impairment in functioning and daily living which presents the biggest challenge to those suffering from obsessive thoughts. Emotions are part of life, but it is when a person begins to feel as if the emotions are controlling or impairing the cadence of their life that a problem arises. Thus, this aspect of ACT is consistent with the goal to diminish the clinical diagnoses of OCD while increasing quality of life (Twohig, et al., 2009).

In ACT, relational frame therapy is used to illuminate how cognitive processes play into psychopathology. Relational frame theory suggests that humankind not only responds to stimuli based on previous experiences with it, but also base their interactions on interrelated stimuli. This is a type of cognition is most developed in verbal human beings. Relational framing is sort of like a connect-the-dots puzzle in that humans can form inferences about a certain thing simply by comparing or associating it with a previously known stimulus. A person may simply be told a novel stimulus is “like this” or “different from” a stimulus they have had a history with and the person can form views and opinions of the novel stimulus without ever actually experiencing it (Twohig, et al., 2009).

In this way, it can be easily seen why relational framing may be considered an evolutionary adaptation related to language as it allows verbal communication to create cognitive connections about whether a novel stimulus is helpful or harmful. For example, a child who

remembers being bitten by a mouse and who has been told rats are just like mice except they bite harder might use the skill of relational framing (both of the mouse bite and levels of hardness in biting) and determine that rats are creatures to be avoided. Relational framing is a cognitive skill that develops across a person's lifespan. Having empathy, or being able to "take the perspective of others" is a skill associated with being better able to relationally frame. Relational framing is considered a higher thought process and deficiency in it may be associated with developmental disabilities (Twohig, et al., 2009).

Relational frame therapy is used in ACT because it places emphasis on the way a thought occurs, not what the content of the thought is. Looking at the "why" and "when" of a thought occurring better allows an intervention at the root of the problem rather than just addressing the content of the thought itself. It can be damaging when a person "connects the dots" of their internal, interconnected thoughts and reality, especially when the two do not coincide. If a person has created views of a novel stimulus that are inaccurate, it may be difficult for them to experience the stimuli how it actually is because they have already formed views and opinions of it.

It may also be hurtful to a person's well-being if they feel their thoughts are dangerous and must be controlled, because they think the cognitions may cause negative consequences. "This leads to a problematic response style called *experiential avoidance*, where people avoid negatively labeled thoughts, feelings, and bodily sensations at the cost of quality of life" (Twohig, et al., 2009; p. 260). Most anxiety disorders revolve around experiential avoidance. Relational framing therapy focuses on the relationship a person has to their world (the way they experience things) rather than the content of what they are experiencing (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Twohig, et al., 2009).

In the relatively few clinical trials that have been conducted thus far, ACT has been found to be successful in a short time at improving client's quality of life for OCD (Twohig, Hayes, & Masuda, 2006; Twohig et al., 2010).

ACT has also been shown to be effective for numerous psychological disorders, not just OCD. Among many other ailments, experiments show ACT to be effective in treating social phobia, depression, workplace stress, and chronic pain (Hayes, 2004). Many, if not all, people will have experienced, at one time or another, having irrational or unwanted thoughts come into their mind.

There are a variety of issues which may be involved in OCD that can lead to the problem of psychological inflexibility. This means the person is unable to adapt their mind to situations. The ability to be flexible is the essential to mental stability. ACT aims help achieve behavioral flexibility. Interestingly, because ACT is a model, many different approaches that are effective can be considered part of the therapy. From the perspective of relational framing, cognitive fusion is the medium through which thought-action fusion can occur. Cognitive fusion can take place with all cognition, including the obsessions in OCD. Thought-action fusion takes place when a person perceives a thought of doing something to be equivalent actually performing the behavior as well as the notion that having a thought makes it more likely to happen in actuality. Cognitive fusion is highly associated with OCD.

Cognitive fusion is dealt with through a process called defusion. Defusion serves to reduce psychological inflexibility and increase behavioral flexibility as mentioned earlier. Defusion techniques achieve this by "broadening stimulus control over behavior." (Twohig, et al., 2009; p. 263). There are many different approaches to defusion but the end result is allowing



the person to feel control over their thought as well as to realize that a thought by itself does not have excessive power in the external world. Initially, it is not the direct goal of defusion to regulate how often the thought occurs.

Both ACT and cognitive therapy discourage clients from trying to regulate or suppress thoughts, which is one form of experiential avoidance. Experiential avoidance can be witnessed when a person (often also connecting stimuli with cognitive fusion) avoids certain situations, people or events which result in negative effects. A client with OCD may attempt thought suppression in order to have more control over their cognition, especially obsessions. However, thought suppression has been shown to be problematic in that attempting to do so often results in the client dwelling on the very thought they are attempting to suppress. This may result in the thought being active in the person's mind with more frequency than if they had not attempted to suppress it in the first place. Some defusion techniques for such a dilemma include recognizing thoughts as they enter the brains as what they are—thoughts. Some people find creating mental images of the thoughts, such as the thoughts floating by in the air, to be helpful aids.

Experiential avoidance can be treated with a model called acceptance. Acceptance is an active process of openly accepting one's inner experiences. It involves recognition of conditions as they actually are in a person's inner world without trying to regulate or suppress these internal factors. The inner stability which acceptance therapy has been shown to foster helps the client in dealing with stimuli which has been cognitively fused in a negative way previously. Acceptance therapy has been shown to be effective in helping a person feel as though they have more control in environments which has been viewed previously as externally unstable.

Psychological inflexibility can result in behavioral inflexibility when a person lacks ability to adapt and respond to the environment immediately surrounding them. Another dimension which promotes better quality of life, and that is addressed by ACT, is being in touch with the present moment. Failing to have contact with the present moment means that a person may not be cued into either their current internal state or the external state of the world without them.

Another component that ACT implements to help clients achieve better quality of life is developing a view of self by context, not content. This means that the person has a more open view of events and experiences, both internal and external. The client is taught to avoid labeling things as “good” or “bad” so readily. Refraining from judgment in this instance may help the client to be able to perceive things as less threatening or damaging. The inner peace this can achieve is beneficial to the client’s feelings of well-being. Having this view of self by context also aids the client in living in the moment as mentioned previously.

Another element that is addressed in ACT is guiding the client to have well-defined and clear cut values. Values are the principles that a person determines to be important enough to pattern their lives after. Values create meaning in a person’s life. Living values is an ongoing effort that a person strives for throughout the course of their lifetime. Values are dynamic and can change dramatically or diminutively throughout development. ACT uses a person’s values to motivate them into learning strategies that will decrease psychological inflexibility. A person’s values may drive them to seek therapy in the first place in order to regain a better quality of life and may also be the driving force to face feared circumstances and other stimuli. Because of this, it is important for clients seeking help through ACT to have clear-cut values.

It is interesting that while values can be a major motivating force, sometimes it is difficult for people to live consistently in accordance with their values. This is especially the case with people struggling with psychological disorders like OCD. In OCD, a person's chosen life values can often fall in rank to the compelling pull of obsessions and compulsions. This could be seen in the case of a person wanting to go out and help an elderly neighbor who is struggling to do yard work, but being held back by an obsession about the germs that are outside. Sometimes people with OCD are mistakenly of the opinion that their symptoms, such as anxiety or fear, must be alleviated prior to taking steps towards living in better accordance with their life values. Because of this, ACT pushes for clients to focus on doing activities that will enhance the meaning of their life without so much focus on how doing such things will affect their internal world. Taking the focus off of the symptoms of OCD and redirecting the client's attention to more meaningful areas can actually be beneficial in reducing the symptoms secondhand.

As was written earlier, ACT aims to promote behavioral flexibility and to break down psychological inflexibility. Behavioral flexibility encourages refraining from unconstructive cognitive fusion, accepting that thoughts are merely thoughts, maintaining contact with the present, seeing oneself in light of context, and having well-defined values. Being flexible behaviorally helps enable a person with OCD to look past the symptoms to focus on what they want to achieve in life and what is most important to them (what they value). People typically believe that in order to achieve better quality of life, the logical order of things would be to first treat their symptoms such as fear or anxiety. However, in accordance with ACT's goals to promote behavioral flexibility, the therapist seeks to understand what a person's values. In understanding their client's values, the therapist becomes better able to help the patient set value-driven goals and focus on achieving them. In this way, there is less emphasis placed on the

client's symptoms, and their quality of life is simultaneously increased as they work towards and meet goals consistent with their values. It is likely, especially initially, for symptoms to be present while the value-driven goals are being sought after.

In contrast to behavioral flexibility, psychological inflexibility tends to promote the opposite sort of behavior. Psychological inflexibility could well be named psychological rigidity because of the unyielding framework it sets for a person's life. Much like viewing life through a frame, psychological inflexibility creates a fixed perspective through which a person must view both internal and external events. This 'frame' narrows a person's perspective and creates a decreased quality of life because of inability to adapt and refocus in certain situations. It is highly probable that a person's 'frame' may not be completely accurate or fully reflect reality. Thus, ACT aims to contest psychological inflexibility.

### **Application of ACT to OCD**

In order to better understand ACT and its role in the treatment of OCD we will discuss a treatment study by Twohig, et al. (2010). Initially, the ACT treatments were similar to other treatments: the material from the past therapy session was reviewed, assignments and events which have transpired since the last session were discussed and new homework assignments and exercises were agreed on. The exercises are called behavioral commitment exercises and are goals agreed upon to aid in having value-driven lifestyles. Session 1 included helping the person to understand what the difference between an obsession and a compulsion is and discussing the person's obsessions and compulsions in depth. In Session 2, the client was taught through an analogy (called the 'Man in the Hole') the destructive role compulsions can play in OCD. The third and fourth sessions expound on how trying to suppress or control obsessions might actually



make them worse. In the fifth and sixth session, the client is taught exercises to help develop behavioral flexibility as mentioned earlier. In Sessions 7 and 8 the client's values and increased behavioral commitment exercises are decided on.

Examples of obsessions include having repeated thoughts of having a dirty house while guests are over, feelings of contamination while at public shopping centers, and feeling needlessly guilty because of religious philosophies. The compulsions in response to such examples might be feeling the need to bleach every household countertop surface, choosing to avoid all public shopping centers and incessant praying for forgiveness. It can easily be discerned that such obsessions and their accompanying compulsions can be harmful to a person's quality of life. Continuing with these three examples, some possible negative consequences of such obsessions and compulsions could be losing time that could have been spent developing better friendships, having to pay the extra cost of shipping from an online source, and choosing not to participate in church activities. Obsessions and compulsions can limit important human interactions and can create added stress to the person experiencing them. As with many psychological disorders, obsessions and compulsions can also affect the quality of life for the people who interact with the person who has OCD. Such examples also illustrate how experiencing OCD might lead to the development of other psychological disorders. Take for example, the final example of a person who obsesses over simple human mistakes and feels compelled to constantly pray for forgiveness. It is easy to imagine such a person slipping into depression or perhaps developing a personality disorder in order to response to the constant feelings of guilt he or she is experiencing.

### **An Application of ACT in Dealing with Undesirable Cognitions**

For my honors thesis project, I created a children's book that incorporates a method of dealing with irrational or unwanted thoughts such as the "obsessions" experienced by those with OCD into the narrative. My goal in writing such a book was to reduce the occurrence of psychological distress amongst the book's audience by illustrating a technique of coping with undesirable thoughts. The technique was written to coincide with the general premise of ACT. The reason I chose a book over a pamphlet or factual document, etc., is that my main audience is children (approximately five to ten years old) would likely find a narrative more engaging.

In choosing to write a children's book, I was aware that relatively few children of the age group I am primarily catering to have a clinical diagnosis of OCD. However, the ability to effectively deal with unwanted thoughts is a useful skill, even for children at these young ages. Developing this skill during childhood may eventually help to prevent a disorder diagnosis in later life.

According to the literature mentioned previously, males receive the majority of pediatric OCD diagnoses. When I learned this information, I considered revising my book to change the main character to a male, but upon further reflection, determined to keep the character a heroine. This is because, in later life, females are more commonly diagnosed with the disorder.

In order to keep my story concise (as well as to make the moral readily apparent) I did not include symptoms of another psychological disorder in the heroine of my story, even though such a co-occurrence of disorders would not be unusual. I merely alluded that the main character, like all people, had experienced psychological distress in the past, which her mother was sensitive to. In the book, this was shown through a conversation between the mother and the

main character, Crissy. Also in an attempt to keep things more simplistic, I avoided discussion of more than one obsession and compulsion throughout the story.

There are multiple elements embedded into the narrative to suggest that Crissy has OCD tendencies. As the story begins, I included reference to Crissy's toy being lined up in rows (symmetry) as well as how many of each type of toy she had (counting).

The technique of dealing with unwanted or irrational thoughts that I chose to implement as the "moral" of my story is based on a major premise of ACT. This moral is the notion that thoughts are simply thoughts, and what is important is to pursue life values rather than dwell on disturbing cognitions.

In my story, Crissy's fear of the dragon did not disappear and, in fact, as consequence of her scary thoughts regarding the dragon she chose not to play Castle any longer, which was a game she had once loved. However, because of the thought-response technique she learned from her mother, she was able to maintain quality of her life despite the obsession: Crissy was still able to get out of bed and enjoy play Pirates with her little brother despite her obsession. This demonstrated the phenomenon of behavioral flexibility.

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